

Financial Assistance Policy

Policy Criteria defining the purpose and use of the Financial Assistance Policy.

Impact (s) Patient Account Receivables with self pay amounts

Date December 01, 2013

Item	Policy
1	<p>Financial Assistance Policy.</p> <p>A Financial Assistance Policy has been established from gifts of money or stock donated to the hospital to help pay for the care of those with financial need. The Fund is used to pay for the cost partially or fully for Inpatient, Outpatient and Emergency services rendered at the hospital. The following is required:</p> <ul style="list-style-type: none">➤ Patients must have a household income at or below 250% of the Federal Poverty Income Guidelines. Proof of Income is required.➤ Patients must complete a Free Bed Fund application.➤ Patients must have applied for financial assistance programs within the State they reside and have been approved/denied eligibility. Proof of Approval/Denial is required. (State Approval may not cover all dates of service in the Financial Assistance Eligibility period.) <p>Financial Assistance Policy has a maximum eligibility period of (3) three months forward. The eligibility period is determined by the date of the Financial Assistance application. Patients must reapply once the determined eligibility period has ended. On all completed applications, the hospital will provide a written notification of acceptance or denial and the reason why within 10 business days. If a patient has been denied for Financial Assistance, he/she may reapply if the reason for denial has changed.</p>

2	<p>Financial Assistance Procedure:</p> <ol style="list-style-type: none">1. The Admissions, Emergency, Social Services and Patient Accounts Departments will have postings of Financial Assistance Funds available in (English, Polish and Spanish) and where to call to obtain information.2. An informational handout describing the hospital Financial Assistance Funds is available in the following areas:<ul style="list-style-type: none">• Admission Department• Emergency Department• Social Service Department• Patient Accounts DepartmentThis handout will be provided upon request or if it has been identified that the patient has exhibited financial need for assistance with their hospital accounts.3. The Patient Accounts department will track:<ol style="list-style-type: none">a. Number of applications approved and funds appliedb. Number of applications denied and the reason why
3	<p>Incomplete Financial Assistance Applications:</p> <p>All incomplete applications received by the Patient Financial Representative, will be returned to the applicant within 10 days of receipt. The returned application will include a detailed cover letter defining why the application was returned. The applicant will have 14 days to return all requested information. After the 14 days, a letter will be mailed to the patient explaining the application has been denied due to information requested to process the application was not received for handling.</p>
6	<p>Search of America</p> <p>All completed applications will be processed through Search of America for the patient's that have a Social Security number. Search of America confirms a patient's income level and provides the Federal Poverty Level for the patient.</p>

7	Plan Codes and Financial Classes Once the application is processed and it is determined whether the patient is eligible for full assistance, or partial assistance the appropriate plan code will be added to the accounts within the eligibility period. Partial Uninsured 800-820 50% FC SU Partial Insured 800-830 50% FC SK Full Insured/Uninsured 800-810 Financial Assistance 100% FC SF Denied FC SR
---	---

[illegible]

Financial Assistance Application Form

(Form Must Be **COMPLETELY** Filled Out – **PLEASE PRINT**)



A Hartford HealthCare Partner

Attention: Patient Accounts Department

Mailing Address: P O Box 100 New Britain CT 06050

Phone: 860-224-5181 Fax: 860-224-5896

Guarantor Name: _____

Patient Name: _____

Medical Rec#: _____ Account #: _____

Address: _____

Social Security #: _____ DOB: _____ Telephone #: _____

Cell Phone #: _____ # of Dependents In Household: _____

Name of Spouse: _____

Are you a WWII Vet? YES ___ NO ___ Is your spouse a WWII Vet? YES ___ NO ___

Name of Dependents:	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospital Account Information

Account Number	List Units #	Date of Service	Balance Due	FC	Diagnosis Description

Income Information

Employer	Patient	Spouse
Gross Wages		
Child Support/Alimony Received		
Pension		
Unemployment Benefits		
Social Security Benefits		
Rental Income Received		
Other Income (<i>please specify</i>)		
TOTAL INCOME		

Before determination will be made, the following information **may** be requested:

- | | |
|---|---|
| <input checked="" type="checkbox"/> Prior Year Tax Return | <input type="checkbox"/> Letter of Support |
| <input type="checkbox"/> Current Pay Stub(s) | <input type="checkbox"/> Social Security Record of Income |
| <input type="checkbox"/> Bank Statement | <input type="checkbox"/> Unemployment Letter |

The above statements are true and accurate. I understand that available funds are used only after all other sources of third party payment have been exhausted. I agree, if requested by the hospital, to cooperate and follow through with applications for State, and/or General Assistance as well as any other Third Party Payors. This application is subject to approval of the Financial Assistance Committee.

Applicant Signature _____ **Date:** _____

Application Taken By: _____

Comments: _____

Approval: _____

Denied: _____

Formulario de solicitud de asistencia financiera

(Debe llenar **COMPLETAMENTE** el formulario - **USE LETRA DE IMPRENTA**)



A Hartford HealthCare Partner

Attention: Patient Accounts Department

Mailing Address: P O Box 100 New Britain CT 06050

(860) 224-5181

Nombre del garante: _____

Nombre del paciente: _____

No. de registro médico: _____ No. de cuenta: _____

Domicilio: _____

No. de seguro social: _____ Fecha de nacimiento: _____ No. de teléfono: _____

No. de teléfono celular: _____ No. de dependientes en el hogar: _____

Paciente: ¿Es un veterano de la segunda guerra mundial? SÍ ☐ NO ☐

Cónyuge: ¿Es un veterano de la segunda guerra mundial? SÍ ☐ NO ☐

Nombre de los dependientes: Fecha de nacimiento: Vínculo:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Información de la cuenta del hospital

Número de cuenta	No. de unidades de lista	Fecha de servicio	Saldo adeudado	FC	Descripción del diagnóstico

Información de los ingresos

Empleador	Paciente	Cónyuge
Sueldo bruto		
Manutención para niños/Pensión alimenticia recibida		
Pensión		
Beneficios de desempleo		
Beneficios del seguro social		
Ingreso de rentas recibido		
Otros ingresos (<i>especifique</i>)		
INGRESO TOTAL		

Antes de que se tome una decisión, se debe proporcionar la siguiente información:

- ☐ Identificación con fotografía, tal como una licencia de conducir, pasaporte o tarjeta de identificación de inmigrante.
- ☐ Prueba de ingresos, tal como una boleta de pago actual, estado de cuenta bancario, registro del seguro social o carta de apoyo financiero.
- ☐ Una carta de aprobación o rechazo del Departamento de Servicios Sociales del Estado de Connecticut para una solicitud médica presentada.

Las declaraciones anteriores son correctas y verdaderas. Entiendo que los fondos disponibles sólo se utilizan después de que se hayan agotado todas las demás fuentes de pago de terceros.

Acepto, si el hospital lo requiere, cooperar y presentar solicitudes para Asistencia general y/o estatal así como cualquier otro tercero responsable de los pagos. Esta solicitud está sujeta a la aprobación del Comité de Asistencia Financiera.

Firma del solicitante _____ **Fecha:** _____

Solicitud tomada por: _____

Comentarios: _____

Aprobación: _____

Rechazada: _____

Formularz z wnioskiem o pomoc finansową

(Niniejszy formularz należy wypełnić **W CAŁOŚCI – PROSZĘ WYPEŁNIĆ PISMEM DRUKOWANYM**)



A Hartford HealthCare Partner

Attention: Patient Accounts Department

Mailing Address: P O Box 100 New Britain CT 06050

(860) 224-5181

Imię i nazwisko poręczyciela: _____

Imię i nazwisko pacjenta: _____

Nr dokumentacji medycznej: _____ Nr rachunku: _____

Adres: _____

Nr Social Security: _____ Data urodzenia: _____ Nr telefonu: _____

Nr telefonu kom.: _____

Liczba osób pozostających na utrzymaniu w gospodarstwie domowym: _____

Pacjent: Weteran II wojny światowej? TAK ____ NIE ____

Małżonek(ka): Weteran II wojny światowej? TAK ____ NIE ____

Imiona i nazwiska osób pozostających na utrzymaniu: _____ Data urodzenia: _____ Powiązanie: _____

Informacje o koncie szpitalnym

Numer konta	Lista Jednostki	Data usługi	Kwota pozostała do	FC	Opis diagnozy

Informacje o dochodach

Pracodawca	Pacjent	Małżonek(ka)
Zarobki brutto		
Otrzymywane zapomoga na dziecko/alimenty		
Emerytura		
Zasiłek dla bezrobotnych		
Świadczenia z tytułu ubezpieczenia społecznego		
Dochód z wynajmu		
Inne <i>(proszę określić)</i>		
CAŁKOWITY DOCHÓD		

Przed rozpatrzeniem wniosku należy dostarczyć następujące informacje:

- ☐ Dokument tożsamości ze zdjęciem, taki jak prawo jazdy, paszport lub karta identyfikacyjna imigranta.
- ☐ Potwierdzenie dochodu, na przykład aktualny odcinek wypłaty, wyciąg z banku, poświadczenie ubezpieczenia społecznego lub deklaracja wsparcia finansowego.
- ☐ Pismo od Departamentu Usług Społecznych Stanu Connecticut z pozytywnym rozpatrzeniem lub odrzuceniem wniosku o pomoc finansową w pokryciu kosztów medycznych.

Powyższe oświadczenia są zgodne z prawdą i dokładne. Rozumiem, że dostępne fundusze są wykorzystywane dopiero po wyczerpaniu wszystkich pozostałych źródeł płatności od stron trzecich. Zgadzam się, na żądanie szpitala, współpracować i realizować kwestię wniosków o pomoc stanową i/lub ogólną, a także od Płatników stron trzecich. Niniejszy wniosek podlega zatwierdzeniu przez Komisję ds. Pomocy Finansowej.

Podpis wnioskodawcy _____ **Data:** _____

Wniosek przyjęty przez: _____

Uwagi: _____

Zatwierdzenie: _____

Odrzucenie: _____

FREE BED FUNDS

If you are coping with a personal financial hardship, and are facing significant debts owed to The Hospital of Central Connecticut, "Free Bed Funds" may be available to cover the cost (partially or fully) for inpatient, outpatient and emergency services rendered at the hospital. The following is required:

- Applied for financial assistance programs within the State you reside and been denied eligibility. **Proof of Denial is Required.**
- Have a household income at or below 250% of the Federal Poverty Income Guidelines. **Proof of Income and/or Assets is Required.**

If you meet the above criteria, to obtain a Free Bed application please contact a Patient Financial Representative at (860) 224-5181 and include the following required documentation when returning the application (parents or guardians may complete, if the patient is a minor):

- A photo I.D. such as a valid CT driver's license, passport or immigration identification card (Green Card)
- A letter of denial from the State of Connecticut Department of Social Services for medical assistance or similar program if not a resident of Connecticut
- Proof of income and/or assets

You are entitled to reapply for Free Bed Funds if previously rejected.

FREE BED FUNDS

Jeśli borykasz się z prywatnymi trudnościami finansowymi i masz duże zadłużenie wobec szpitala Central Connecticut, koszty usług hospitalizacji, ambulatoryjnych oraz ratunkowych świadczonych przez szpital mogą zostać pokryte (całkowicie lub częściowo) z funduszu Free Bed Funds. Warunki są następujące:

- Złożenie wniosku o pomoc finansową w stanie zamieszkania i odmowa jej przyznania. **Wymagane jest świadectwo odmowy.**
- Całkowity dochód gospodarstwa domowego na poziomie 250% federalnego minimum ubóstwa lub poniżej. **Wymagane jest świadectwo dochodów i/lub majątku.**

Jeśli spełniasz te kryteria, zadzwoń do działu relacji finansowych z pacjentami pod numer (860) 224-5181, aby otrzymać wniosek o dofinansowanie z funduszu Free Bed Fund i dołącz następujące dokumenty do wypełnionego wniosku (jeśli pacjent jest niepełnoletni, mogą go za niego wypełnić rodzice lub opiekunowie):

- dowód tożsamości ze zdjęciem, jak np. prawo jazdy wydane w stanie Connecticut, paszport lub karta stałego pobytu (zielona karta);
- pisemną odmowę pokrycia kosztów leczenia przez Wydział Opieki Społecznej stanu Connecticut lub pisemną odmowę przyznania innej pomocy finansowej w przypadku zamieszkania poza stanem Connecticut;
- świadectwo dochodów i/lub majątku.

Możliwe jest ponowne składanie wniosku o dofinansowanie z funduszu Free Bed Funds w przypadku jego wcześniejszego odrzucenia.

FONDOS PARA CAMAS GRATUITAS

Si usted se encuentra enfrentando una dificultad financiera, y tiene grandes deudas con The Hospital of Central Connecticut, los "Fondos para camas gratuitas" pueden estar disponibles para cubrir (parcial o totalmente) el costo para servicios de internación, ambulatorios y de emergencia brindados en el hospital. Los siguientes requisitos son obligatorios:

- Haber solicitado programas de asistencia financiera del estado en el que reside y que estos hayan sido rechazados. **Se exige prueba del rechazo.**
- Contar con un ingreso familiar del 250% o menor del Parámetro Federal de Pobreza. **Se exigen pruebas de ingresos y bienes.**

Si cumple con los criterios mencionados, contáctese con un Representante Financiero para Pacientes para obtener una solicitud para camas gratuitas al (860) 224-5181 e incluya la siguiente documentación exigida cuando devuelva la solicitud (padres o tutores pueden completarla, si el paciente es menor de edad):

- Una identificación con foto, como una licencia de conducir vigente de CT, pasaporte o cédula de identificación inmigratoria (Tarjeta de Residencia);
- Una carta de rechazo del Departamento de Servicios Sociales del Estado de Connecticut para brindarle asistencia médica o de un programa similar si no es residente de Connecticut;
- Prueba de ingresos y bienes

Tiene derecho a solicitar nuevamente los Fondos para camas gratuitas si su solicitud ha sido rechazada previamente.

Patient Payment Arrangements

Policy Criteria defining Patient Payment Arrangements for patient's accounts.

Impact (s) Patient Account Receivables

Item	Policy								
1	<p>Patient Payment Guidelines:</p> <p>The guidelines below define the amount and terms that THOCC can accept as a payment plan from the patient. The balance range is for all accounts owed by the patient NOT at a Collection Agency.</p> <table> <tr> <td><u>Balance Range:</u></td><td><u>Term:</u></td></tr> <tr> <td>\$10.00-\$249.99</td><td>No Arrangements</td></tr> <tr> <td>\$250.00-\$500.00</td><td>6 Months</td></tr> <tr> <td>\$500.01-\$2400.00+</td><td>12 Months</td></tr> </table>	<u>Balance Range:</u>	<u>Term:</u>	\$10.00-\$249.99	No Arrangements	\$250.00-\$500.00	6 Months	\$500.01-\$2400.00+	12 Months
<u>Balance Range:</u>	<u>Term:</u>								
\$10.00-\$249.99	No Arrangements								
\$250.00-\$500.00	6 Months								
\$500.01-\$2400.00+	12 Months								
2	<p>Canceling a Patient Payment Plan:</p> <p>If the patient misses an installment of their payment plan and can not make the payment up in the next month's statement, the system will prelist the account for collection. Otherwise, the patient may pay their balance in full to avoid collection action. The patient or guarantor also may call to change their payment plan, so long as it is within our guidelines.</p>								
3	<p>Patient Unable to make Payment Plan per Policy:</p> <p>When patient/guarantor contacts the customer service department and informs them of being unable to make payment on their accounts per policy guidelines, we are responsible to inform the patient of potential state and hospital assistance available to cover the cost (partially or fully) for Inpatient, Outpatient and Emergency Services rendered at the hospital. (Refer to FA policy for detail requirements)</p>								

Bad Debt Guidelines and returns policy

Overview Insures that accounts are appropriately handled for transfer to Bad Debt.

Policy Account requirements prior to transfer to Bad Debt.

Impact (s) The placement of accounts in Bad Debt location.

Seq#	Policy
1	<p>The Pre-List Selection Report (FFR300) is produced during the last week of the month to identify all accounts eligible for transfer to Bad Debt during midnight processing on the last day of the month. Accounts are selected based on the following criteria:</p> <ul style="list-style-type: none"> • Balance is patient's responsibility • Payment in full has not been received during the 4 statement cycle (approx. 120 days) • If the patient's responsible balance of an account is \$24.99 or less, 2 statements will be sent to the patient. If the balance remains unpaid after 90 days, the Patient Financial Services System will post an automatic allowance to the account to bring the balance to \$0.00. • If the patient's responsible balance of an account is \$9.99 or less, the Patient Financial Services System will post an automatic allowance to the account to bring the balance to \$0.00.
2	<p>The Pre-List Selection Report is reviewed by the collection staff during the last week of the month for:</p> <ul style="list-style-type: none"> • Alternative sources of payment. • If patient has made 2 or more consecutive payments on the account and the criteria for a payment plan is met, the payment plan is established. • Review 'holds' on account and work appropriately, i.e. check probate, etc.
3	<p>The Pre-List Exception Report (FFR385) is produced during the last week of the month to identify all accounts eligible for transfer to Bad Debt, but have the following exceptions and will not transfer:</p>

	<ul style="list-style-type: none">• Account Balance is not completely the patient's responsibility.• Account has a credit balance.• Account Balance is \$25,000 and greater.
4	The Pre-List Exception Report is reviewed by collection staff for: <ul style="list-style-type: none">• Alternative sources of payment.
5	Accounts over \$25,000.00 or greater and do not qualify for items listed in sequence 4, need review/approval by the Chief Executive Officer. Send screen print with reason for turn over to obtain approval before account is prelisted for Bad Debt. After approval received and account prelisted, note account with date approval signed.
6	The collection agency is responsible to provide the hospital's financial assistance summary information with each collection notice (PA 3-266). If a patient contacts either the hospital or collection agency to apply for such funds, the collection agency is responsible to stop collection activity until notified by the hospital of the outcome of application. .
7	Exception to sequence #1. If a Patient's account has a statement returned by the post office with an invalid address that can not be forwarded, the account is flagged in Star to notify admitting of the incorrect address for future visits, Bad Address. The collection staff will select 'end step' on follow up maintenance screen, and account will fall on the bad debt selection list on the 23 rd of the month.
8	Exception to sequence #1. Self-pay admissions that are not collectable through standard practices are referred to an outside vendor that acts on our behalf to establish Medicaid eligibility.
9	Exception to sequence #1. Patient is expired and there is no estate or other means for payment, the account is adjusted using a no estate adjustment.
10	Exception to sequence #1. If a patient is homeless or has no known address, the account is adjusted using an uncollectable adjustment.

11	<p>Financial Assistance: Patients who qualify for financial assistance will have their bill reduced to the appropriate amount. The accounts that have been processed through financial assistance will be identified by the following financial classes SK insured/partial, SU uninsured/partial, SB hardship or SR denied.</p> <p>BAD DEBT RETURNS:</p> <p>Our collection agencies will return accounts worked and found to be: deceased, skipped, bankrupt, or other to be adjusted off. The remaining accounts are worked until they have exhausted all efforts and then returned to THOCC. If applicable, those accounts will be reassigned to a secondary collection agency for follow up collection.</p> <p>An electronic email with returned uncollectable accounts is sent by agency to THOCC each month.</p> <p>The THOCC cashier manually enters the file and accounts are written off under transaction code 8047 uncollectable.</p>
12	<p>Search of America</p> <p>Accounts prelisted for Bad Debt are run through the Search of America system to obtain the patient's Federal Poverty Level.</p> <p>A file is received with the Federal Poverty Level to identify patients that qualify for partial or full financial assistance.</p> <p>Federal Poverty Level up to 250% receives full assistance. Federal Poverty Level above 250% and up to 400% receive partial assistance.</p> <p>The accounts are adjusted for the amount determined by Federal Poverty Level partial or full using the Financial Assistance adjustment of 9005.</p>

Hartford Healthcare Financial Assistance Policy

Update Date: 12/16/2010

Purpose: The purpose of this Policy is to set forth the policy of Hartford Healthcare Corporation (sometimes referred to as the "System") governing the provision of free or discounted Health Care Services to patients who meet the System's criteria for Financial Assistance. Specifically, this Policy will describe: (i) the eligibility criteria for Financial Assistance, and whether such assistance includes free or discounted care; (ii) the basis for calculating amounts charged to patients; (iii) the method for applying for Financial Assistance from the System's Hospitals; (iv) the actions the System may take in the event of non-payment, including collections action and reporting to credit agencies for patients that qualify for Financial Assistance; and (v) the System measures to widely publicize this Policy within the community served by Hartford Healthcare.

Scope: This Policy applies to all Hartford Health facilities Health Care Services regardless of the location at which they are being provided by the System.

Definitions:

"Charges" means for a Health Care Service for a patient who is either Uninsured or Underinsured and who is eligible for Financial Assistance, the average of the System's facility three best negotiated commercial payor rates for the Health Care Services.

"Eligibility Criteria" means the criteria set forth in this Policy to determine whether a patient qualifies for Financial Assistance for the Health Care Services provided by the System's facility.

"EMTALA" means the Emergency Medical Treatment and Labor Act, 42 USC 1395dd, as amended from time to time.

"Family" means pursuant to the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, civil union or adoption. For purposes of this Policy, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

"Family Income" means the following income when calculating Federal Poverty Level Guidelines of liquid assets: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources of income. If a person lives with a Family, Family Income includes the income of all Family members.

"Federal Poverty Level Guidelines" means the federal poverty level guidelines established by the United States Department of Health and Human Services.

"Financial Assistance" means free or discounted Health Care Services provided to persons who, pursuant to the Eligibility Criteria, the Hospital has determined to be unable to pay for all or a portion of the Health Care Services.

"Free Bed Funds" means any gift of money, stock, bonds, financial instruments or other property made by any donor to Hartford Healthcare facilities for the purpose of establishing a fund to provide medical care to an inpatient or outpatient of Hartford Healthcare.

"Health Care Services" means Hartford Healthcare facilities (i) emergency medical services as defined by EMTALA; (ii) services for a condition which, if not promptly treated, will result in adverse change in the health status of the individual; (iii) non-elective services provided in response to life-threatening circumstances in a non-emergency department setting; and (iv) medically necessary services as determined by the System facility on a case-by-case basis at the facility's discretion.

"Medically Indigent" means persons whom the System facility has determined to be unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their Family Income or Family assets even though they have income or assets that otherwise exceed the generally applicable Eligibility Criteria for free or discounted care under the Policy.

"Uninsured" means a patient who has no level of insurance or third party assistance to assist in meeting his or her payment obligations for Health Care Services and is not covered by Medicare, Medicaid or Champus or any other health insurance program of any nation, state, territory or commonwealth, or under any other governmental or privately sponsored health or accident insurance or benefit program including, but not limited to workers' compensation and awards, settlements or judgments arising from claims, suits or proceedings involving motor vehicle accidents or alleged negligence.

"Underinsured" means the patient has some level of insurance or third-party assistance but still has out-of-pocket expenses such as high deductible plans that exceed his or her level of financial resources.

Policy: It is Hartford Healthcare's policy to provide Financial Assistance to all eligible individuals who are Uninsured, Underinsured, ineligible for a government program, or otherwise unable to pay for Health Care Services due to their limited financial resources. It is also the System's policy to provide without discrimination care for emergency medical conditions (as defined by EMTALA) to individuals regardless of their eligibility for Financial Assistance under this Policy or for government assistance.

I. Determining Eligibility.

In determining eligibility for Financial Assistance, it is important that both the System facility and the patient work collaboratively. Specifically, the System facilities

will do its best to apply the Eligibility Criteria in a flexible and reasonable manner and the patient will do its best in responding to Hartford Healthcare requests for information in a timely manner.

1. Eligibility for Financial Assistance. Individuals who are Uninsured, Underinsured, ineligible for any government health care benefit program and unable to pay for their Health Care Services may be eligible for Financial Assistance pursuant to this Policy. The granting of Financial Assistance shall be based upon an individualized determination of financial need, and shall not take into account age, gender, race, color, national origin, marital status, social or immigrant status, sexual orientation or religious affiliation.

2. Process for Determining Eligibility for Financial Assistance. In connection with determining eligibility for Financial Assistance, the System (i) will require that the patient complete an application for Financial Assistance along with providing other financial information and documentation relevant to making a determination of financial eligibility; (ii) may rely upon publicly available information and resources to determine the financial resources of the patient or a potential guarantor; (iii) may pursue alternative sources of payment from public and private payment benefit programs; (iv) may review the patient's prior payment history; and (v) may consider the patient's receipt of state-funded prescription programs, participation in Women, Infants and Children programs, food stamps, subsidized school lunches, subsidized housing, or other public assistance as presumptive eligibility when there is insufficient information provided by the patient to determine eligibility.

3. Processing Requests. Hartford Healthcare will use its best efforts to facilitate the determination process prior to rendering services so long as the determination process does not interfere with the provision of emergency medical services as defined under federal law. However, eligibility determinations can be made at any time during the revenue cycle. During the eligibility determination process, the System facilities will at all times treat the patient or their authorized representative with dignity and respect and in accordance with all state and federal laws.

4. Financial Assistance Guidelines. Eligibility criteria for Financial Assistance may include, but is not limited to, such factors as Family size, liquid and non-liquid assets, employment status, financial obligations, amount and frequency of healthcare expense (i.e. Medically Indigent) and other financial resources available to the patient. Family size is determined based upon the number of dependents living in the household. In particular, eligibility for Financial Assistance will be determined in accordance with the following guidelines:

(a) Uninsured Patients:

- (i) If Family income is at or below 250% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 100% discount against the System facility's Charges for Health Care Services;

- (ii) If Family income is between 250% and 400% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 50% discount against the System facility's Charges for Health Care Services;
- (iii) Patients may also qualify for Free Bed Funds in accordance with the Hartford Healthcare Free Bed Funds Policy; and
- (iv) Patients may have presumptive eligibility if they are homeless and have no assets or qualify for other means-tested government programs.

(b) *Underinsured Patients:*

- (i) Payment plans will be extended for any patient liability (including without limitation to amounts due under high deductible plans) identified in a manner consistent with the System's Payment Plan Policy;
- (ii) If Family Income is at or below 250% of the Federal Poverty Level Guidelines, the patient may qualify for up to a 100% discount against the lesser of (a) the account balance after insurance payments from third-party payors are applied; or (b) the Charges for the Health Care Services;
- (iii) If Family Income is between 250% and 400% of the Federal Poverty Level Guidelines, the patient may qualify for up to 50% discount against the lesser of (a) the account balance after insurance payments from third-party payors are applied; or (b) the Charges for the Health Care Services;
- (v) Patients may also qualify for Free Bed Funds in accordance with Hartford Healthcare Free Bed Funds Policy; and
- (vi) Patients may have presumptive eligibility if they are homeless and have no assets or qualify for other means-tested government programs.

- (c) ***Medically Indigent:*** Patients will be required to submit a Financial Assistance application along with other supporting documentation, such as medical bills, drug and medical device bills and other evidence relating to high-dollar medical liabilities, so that the Hartford Healthcare System Hardship Committee can determine whether the patient qualifies for Financial Assistance due to the patient's medical expenses and liabilities.

II. Method for Applying for Financial Assistance. Patients may ask any nurse, physician, chaplain, or staff member from Patient Registration, Patient Accounts, Office of Professional Services, Case Coordination, or Social Services about initiating the Financial Assistance application process. Information about applying for Financial Assistance is

also available online at www.hartfordhealthcare.org. Signage and written information regarding how to apply for Financial Assistance will be available in Hartford Healthcare facilities' emergency service and patient registration areas. Once a patient or his or her legal representative requests information about Financial Assistance, a Financial Counselor will provide the patient or his or her legal representative with the Financial Assistance application along with a list of the required documents that must be provided to process the application. If the patient or his or her legal representative does not provide the necessary documentation and information required to make a Financial Eligibility determination within fourteen (14) calendar days of the Hartford Healthcare facility's request, the Financial Assistance application will be deemed incomplete and rendered void. However, if an application is deemed complete by the System facility, the System facility will provide to the patient or his or her legal representative a written determination of financial eligibility within five (5) business days. Decisions by the System facilities that the patient does not qualify for Financial Assistance may be appealed by the patient or his or her legal representative within fourteen (14) calendar days of the determination. If the patient or his or her legal representative appeals the determination, the Director of Patient Access will review the determination along with any new information and render a final decision within five (5) business days.

III. Relationship to Hartford Healthcare Collection Practices. In the event a patient fails to qualify for Financial Assistance or fails to pay their portion of discounted Charges pursuant to this Policy, and the patient does not pay timely their obligations to Hartford Healthcare, the System reserves the right to institute and pursue collection actions and to pursue any remedies available at law or in equity, including but not limited to, imposing wage garnishments or filing and foreclosing on liens on primary residences or other assets, instituting and prosecuting legal actions and reporting the matter to one or more credit rating agencies. For those patients who qualify for Financial Assistance and who, in the System's sole determination, are cooperating in good faith to resolve the System's outstanding accounts, the System facilities may offer extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences, will not send unpaid bills to outside collection agencies and will cease all collection efforts.

IV. Publication and Education. Hartford Healthcare facilities will disseminate information about its Financial Assistance Policy as follows: (i) provide signage regarding this Policy and written summary information describing the Policy along with financial assistance contact information in the Emergency Department, Labor and Delivery areas and all other System patient registration areas; (ii) directly provide to each patient written summary information describing the Policy along with financial assistance contact information in all admission, patient registration, discharge, billing and collection written communications; (iii) post the Policy on the System's web site with clear linkage to the Policy on the System's home page; (iv) educate all admission and registration personnel regarding the Policy so that they can serve as an informational resource to patients regarding the Policy; and (v) include the tag line "Please ask about our Financial Assistance Policy" in all Hartford Healthcare written advertisements.

V. Relation to Free Bed Funds. If a patient applies for Financial Assistance, Hartford Healthcare facilities will determine his or her eligibility for Financial Assistance and or Free Bed Funds.

VI. Regulatory Compliance. The System will comply with all state and federal laws, rules and regulations applicable to the conduct described in this Policy.

Reviewed By: Niobus Queiro, Revenue Cycle Director, Hartford Healthcare Corporation
Shelly McCafferty, PFS Director, Hartford Healthcare Corporation
Becky Peters, PAS Director, Hartford Hospital
Joan Feldman, Legal Counsel to Hartford Healthcare Corporation

Approved By: _____ Thomas Marchozzi, EVP & CFO Hartford Healthcare Corp.

Date: _____ October 1, 2010 _____

Issued Date: 08/16/2010